CGS Answer/Comments:

CMS NCDs

All NCDs are followed by original Medicare and MAOs

- MAOs are expected to stay apprised of new and/or changing Medicare Part A and Part B coverage policies, including those that result from CMS's National Coverage Determination (NCD) process.

MAO plans vs MACs LCD

MA plans that work out of multiple jurisdictions can either:

- Use a MACs LCD within the jurisdiction where they provide enrollment
- Develop their own policy, and not follow a MAC's LCD

Example:

- Humana MA plan provides enrollment to Medicare beneficiaries in the following stats:
- Ohio – CGS
- California – Noridian
- Texas – Novitas
- Alabama – Palmetto GBA

Humana can select one of the above MACs LCD/Policy or have a policy developed by Humana that will identify coverage requirements for that procedure/service

Reference: Medicare Managed Care Manual Chapter 4 - Benefits and Beneficiary Protections sections 90 – 90.6 https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf

QUESTION:

Medicare open enrollment, I thought that a patient could only change their MCO during open enrollment during the Fall. I have come across several patients where they are changing MCO in the beginning of the year of 2024?

CGS Answer/Comments:

Medicare open enrollment for 2024 Open Enrollment Period October 15-December 7.

- There maybe circumstances when an enrollee may need to make a change to their enrollment plan, after the effective date or when there is a National or State of emergency that would identify for a change in an enrollment plan.
- This is why it is always best to verify Medicare enrollment whether for MA plans or to confirm their MBI for original Medicare has not changed since their last encounter with that provider
    - Providers can access CGS myCGS (cgsmedicare.com)
        - myCGS portal 24/7 and it is free of charge to all CGS providers. myCGS offers a variety of functions, such as, access to beneficiary eligibility, claim and payment information, forms allowing you to submit redetermination requests, and respond to Medical Review Additional Documentation Requests (ADR), and much more. Refer to the myCGS User Manual Web page for more details.

Medicare Advantage Open Enrollment Period
(only if they are already in a Medicare Advantage Plan)

- January 1-March 31.
- Within the first 3 months they get Medicare

Reference Medicare.Gov https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan

QUESTION:
J-codes, Is there a website or document that we can use to review to see what Units and measures are required for NDC? We have been using Codify but are receiving denials.

CGS Answer/Comments:

As a MAC we would not have any recommendations on what vendor can be used, you can check to see if the National Drug Code Directory identifies any vendors at:

https://www.bing.com/search?q=Drug+NDC&cvid=3f36cce59adc483292e39bce531c8b98&gs_lcrp=EgZjaHJvbWUyBggAEEUYOdIBCDY5MTJqMGo0qAIAsAIA&FORM=ANAB01&PC=U531 (fda.gov)

QUESTION:
When is it appropriate to bill an E&M with an injection?

CGS Answer/Comments:

When the E/M is a separately identifiable service, the provide can review the following to determine if a modifier is required or if the service can be billed separately:

NCCI - https://www.cms.gov/medicare/coding-billing/ncci-medicare

IOM 100-04 chapter 12 section 30 https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

QUESTION:
We are a multi-specialty and subspecialty practice with multiple PAs and NPs. According to CPT guidelines, a new patient is someone who has not been seen within the last 3 years by the exact same specialty and subspecialty who belongs to the same group practice. When NPs and PAs are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.
Example: A Nurse practitioner who's supervising physician specialty is pain anesthesia is seeing a patient who saw one of our physician assistants who's supervising physician is an orthopedic surgeon subspecialty spine. The new patient E&M for the nurse practitioner is denied because new patient qualifications were not met.
What can we do to get these paid according to the CPT guidelines?

CGS Answer/Comments:

The PAs or NPs will need to identify the specialty they are employed under and that they are not working under the same specialty as the physician (MD/DO), for their service to be considered for payment.

IOM 100-04-chapter 12 section 30 **https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf**

- 30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99202 - 99215) (Rev. 12461; Issued:01-18-24; Effective:01-01-24 Implementation: 02-19-24) A. Definition of New Patient for Selection of E/M Visit Code Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3-year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

CGS Concurrent Care publication Revised Concurrent Care – E/M Service: Similar Services from Multiple Providers and Non Physician Practitioners Within the Same Group (cgsmedicare.com)

As a reminder, please take the CGS Survey to help direct future presentations. The survey can be found on the last page of the CGS handout.